1-1-2011

Goudy-Bachman v. HHS - U.S. Motion to Dismiss

United States Department of Health and Human Services

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

BARBARA GOUDY-BACHMAN; and GREGORY BACHMAN, Plaintiffs, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; KATHLEEN SEBELIUS, in her official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF THE TREASURY; and TIMOTHY F. GEITHNER, in his official capacity as Secretary of the United States Department of the Treasury, Defendants.	)	Civil Action No. 1:10-cv-00763-CCC (Judge Christopher C. Conner)

MEMORANDUM IN SUPPORT OF
DEFENDANTS' MOTION TO DISMISS

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INTRODUCTION

Plaintiffs seek here to challenge recently enacted federal health care reform legislation. To accept their claim, this Court would have to make new law and ignore decades of settled precedent. The Court would also have to step beyond the proper role of the Judiciary, for plaintiffs do not satisfy the basic constitutional prerequisites – in particular, standing to sue – to invoke federal jurisdiction. The only provision plaintiffs challenge in this litigation – Section 1501 of the Patient Protection and Affordable Care Act ("ACA" or the "Act") – requires individuals, beginning in 2014, either to maintain a minimum level of health insurance coverage or to pay a penalty if they do not. This provision imposes no current obligation on plaintiffs, and many potential changes in plaintiffs' financial, employment, or health status before 2014 could keep the provision from affecting them in the future in the way that they anticipate. Plaintiffs cannot manufacture an imminent injury-in-fact by claiming that, because they will have to spend part of their otherwise-disposable income on insurance as of January 1, 2014, they are currently unable to enter into a five-year financing plan to purchase a new car. Any decision plaintiffs make not to buy a new car now depends on speculative assumptions about the future and is not fairly traceable to the Act. To hold otherwise would allow plaintiffs, by dint of anticipation, to convert any remote contingency into a current harm. Plaintiffs therefore lack standing to sue, the fundamental prerequisite to invoke the jurisdiction of this Court. As the Supreme Court has stated, "Except when necessary in the execution of th[eir] function [to redress or prevent actual or imminently threatened injury to persons caused by private or official violation of law], courts have no charter to review and revise legislative and executive action. This limitation is founded in concern about the proper – and properly limited – role of the courts in a democratic society." *Summers v. Earth Island Inst.*, 129 S. Ct. 1142, 1148 (2009) (internal quotation and citation

omitted); *see Massachusetts v. Mellon*, 262 U.S. 447, 489 (1923) (warning that to decide the constitutionality of a statute in the absence of a judicial controversy would be to "assume a position of authority over the governmental acts of another and coequal department, an authority which [the Court] plainly do[es] not possess."). Plaintiffs' claim thus fails before the Court can reach the merits.

Even if plaintiffs could surmount this jurisdictional barrier, their claim still would fail because Congress, in adopting the minimum coverage provision, acted well within its authority under the Commerce Clause. Congress understood that virtually everyone at some point will need medical services, which cost money. The ACA merely regulates economic decisions on how to pay for those services – whether to pay in advance through insurance or attempt to do so later out of pocket – decisions that "bear[] a clear and significant relation" to the vast, interstate health care market. *United States v. Whited*, 311 F.3d 259, 267-68 (3d Cir. 2002).

As Congress found, Americans spent an estimated $2.5 trillion on health care in 2009. Pub. L. No. 111-148, §§ 1501(a)(2)(B), 10106(a), 124 Stat. 119, 907 (2010). Even so, more than 45 million Americans have neither private health insurance nor the protection of government programs such as Medicaid. Many of these individuals are uninsured because they cannot afford coverage. Others are excluded by insurers' restrictive underwriting criteria. Still others make the economic decision to forego insurance altogether.

Foregoing health insurance, however, is not the same as foregoing health care. When accidents or illnesses inevitably occur, the uninsured still receive medical assistance, even if they cannot pay. As Congress documented, such uncompensated health care costs – $43 billion in 2008 – are passed on to the other participants in the health care market: the federal government, state and local governments, health care providers, insurers, and the insured population. Pub. L.

No. 111-148, §§ 1501(a)(2)(F), 10106(a).

Recognizing that the pervasive ills in the health care system require a national solution, Congress adopted a variety of interrelated provisions to reduce the number of uninsured Americans. To make health insurance affordable and available, the Act provides for "health benefit exchanges" through which individuals and small businesses may leverage their collective buying power to obtain prices for health insurance that are competitive with group plans. It provides incentives for employers to offer expanded insurance coverage. It offers tax credits to certain low-income and middle-income individuals and families, and extends Medicaid to individuals with lower incomes. And it prohibits insurers from denying coverage to those with pre-existing medical conditions, imposing eligibility rules based on medical factors or claims experience, or revoking insurance other than for fraud or misrepresentation.

The "minimum coverage provision" that plaintiffs challenge here – *i.e.*, the requirement that, with specified exceptions, all Americans who can afford it either maintain a minimum level of health insurance coverage or pay a penalty – is a linchpin of Congress's reform plan. *See id.* §§ 1501(a)(2)(H), 10106(a) (absence of minimum coverage requirement would "undercut Federal regulation of the health insurance market"). Based on extensive hearings and expert evidence, Congress found that requiring the financially able to purchase health insurance would spread risks across a larger pool, which (as with all insurance) would allow insurers to charge less for coverage. *Id.* §§ 1501(a)(2)(I), 10106(a). Conversely, Congress determined that, without the minimum coverage provision, the reforms in the Act, such as the ban on denying coverage based on pre-existing conditions, would not work, as they would amplify existing incentives for individuals to "wait to purchase health insurance until they needed care," which in turn would shift even greater costs onto third parties. *Id.* §§ 1501(a)(2)(I), 10106(a). The

minimum coverage provision, Congress concluded, is "essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." *Id.*

More broadly, the findings in the Act underscore the rational basis for Congress's conclusion that, "taken in the aggregate," economic decisions to try to pay for health care out of pocket, rather than to pay in advance through insurance, substantially affect interstate commerce. *Gonzales v. Raich*, 545 U.S. 1, 22 (2005). Among other things, these decisions shift costs to third parties, Pub. L. No. 111-148, §§ 1501(a)(2)(F), 10106(a); "increas[e] financial risks to households and medical providers," *id.* §§ 1501(a)(2)(A), 10106(a); raise insurance premiums, *id.* §§ 1501(a)(2)(F), 10106(a); precipitate personal bankruptcies, §§ 1501(a)(2)(G), 10106(a); and impose higher administrative expenses, *id.* §§ 1501(a)(2)(J), 10106(a). Against this backdrop, Congress's authority under the Commerce Clause to impose the minimum coverage provision is clear.

The Commerce Clause, moreover, is not the only source of Congressional power to adopt this statute. Congress also has independent and "extensive" authority to do so as an exercise of its power under Article I, Section 8, to lay taxes and make expenditures to promote the general welfare. *License Tax Cases*, 72 U.S. (5 Wall.) 462, 471 (1866). The Court has held that an exercise of this power is valid even if it has a regulatory function, even if the revenue purpose is subsidiary and the moneys raised "negligible," and even if Congress could not otherwise assert regulatory authority. *United States v. Sanchez,* 340 U.S. 42, 44 (1950). The minimum coverage provision – which is enforced through a provision in the Internal Revenue Code requiring individuals to pay a penalty with their taxes if they lack required coverage – raises more than negligible revenue. It is a valid exercise of this broad power.

In sum, because plaintiffs lack standing to sue, this case does not call upon the Court to judge the "constitutionality of an Act of Congress" – "'the gravest and most delicate duty'" a court may undertake. *Nw. Austin Mun. Util. Dist. No. One v. Holder*, 129 S. Ct. 2504, 2513 (2009) (quoting *Blodgett v. Holden,* 275 U.S. 142, 147-48 (1927) (Holmes, J., concurring)). Even if the Court were to undertake that task, however, clear precedent establishes that the minimum coverage provision falls within Congress's authority to regulate interstate commerce, as well as its power to lay taxes and make expenditures for the general welfare.

Accordingly, the Motion to Dismiss should be granted.

STATUTORY BACKGROUND

In 2009, the United States spent more than 17% of its gross domestic product on health care. Pub. L. No. 111-148, §§ 1501(a)(2)(B), 10106(a). Notwithstanding these extraordinary expenditures, 45 million people – an estimated 15% of the population – went without health insurance for some portion of 2009, and, absent the new legislation, that number would have climbed to 54 million by 2019. CONG. BUDGET OFFICE ("CBO"), 2008 KEY ISSUES IN ANALYZING MAJOR HEALTH INSURANCE PROPOSALS 11 (Dec. 2008) [hereinafter KEY ISSUES]; *see also* CBO, THE LONG-TERM BUDGET OUTLOOK 21-22 (June 2009).

The record before Congress documents the staggering costs that a broken health care system visits on individual Americans and the nation as a whole. The millions who have no health insurance coverage still receive medical care, but often cannot pay for it. The costs of that uncompensated care are shifted to the government, taxpayers, insurers, and the insured. But cost shifting is not the only harm imposed by the lack of insurance. Congress found that the "economy loses up to $207,000,000,000 a year because of the poorer health and shorter lifespan of the uninsured," Pub. L. No. 111-148, §§ 1501(a)(2)(E), 10106(a), and concluded that 62

percent of all personal bankruptcies are caused in part by medical expenses, *id.* §§ 1501(a)(2)(G), 10106(a). All these costs, Congress determined, have a substantial effect on interstate commerce. *Id.* §§ 1501(a)(2)(F), 10106(a).

In order to remedy this enormous problem for the American economy, the Act comprehensively "regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when health insurance is purchased." Pub. L. No. 111-148, §§ 1501(a)(2)(A), 10106(a). First, to address inflated fees and premiums in the individual and small-business insurance market, Congress established health insurance exchanges "as an organized and transparent marketplace for the purchase of health insurance where individuals and employees (phased-in over time) can shop and compare health insurance options." H.R. REP. NO. 111-443, pt. II, at 976 (2010) (internal quotation omitted). The exchanges regulate premiums, coordinate participation and enrollment in health plans, and provide consumers with needed information. Pub. L. No. 111-148, § 1311.

Second, the Act builds on the existing system of health insurance, in which most individuals receive coverage as part of their employee compensation. *See* CBO, KEY ISSUES, at 4-5. It creates a system of tax incentives for small businesses to encourage the purchase of health insurance for their employees, and imposes penalties on certain large businesses that do not provide adequate coverage to their employees. Pub. L. No. 111-148, §§ 1421, 1513.

Third, the Act subsidizes insurance coverage for a large portion of the uninsured population. As Congress understood, nearly two-thirds of the uninsured are in families with income less than 200 percent of the federal poverty level, H.R. REP. NO. 111-443, pt. II, at 978 (2010); *see also* CBO, KEY ISSUES, at 27, while 4 percent of those with income greater than 400 percent of the poverty level are uninsured. CBO, KEY ISSUES, at 11. The Act seeks to plug this

gap by providing health insurance tax credits and reduced cost-sharing for individuals and families with income between 133 and 400 percent of the federal poverty line, Pub. L. No. 111-148, §§ 1401-02, and expands eligibility for Medicaid to individuals with income below 133 percent of the federal poverty level beginning in 2014. *Id*. § 2001.

Fourth, the Act removes barriers to insurance coverage. As noted, it prohibits widespread insurance industry practices that increase premiums – or deny coverage entirely – to those with the greatest need for health care. Most significantly, the Act bars insurers from refusing to cover individuals with pre-existing medical conditions. *Id.* § 1201.[1]

Finally, the Act requires that all Americans, with specified exceptions, maintain a minimum level of health insurance coverage, or pay a penalty. *Id.* §§ 1501, 10106.[2] Congress found that this provision "is an essential part of th[e] [Act's] larger regulation of economic activity," and that its absence "would undercut Federal regulation of the health insurance market." *Id.* §§1501(a)(2)(H), 10106(a). That judgment rested on a number of Congressional findings. Congress found that, by "significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will lower health insurance premiums." *Id.* §§ 1501(a)(2)(F), 10106(a). Conversely, and importantly, Congress found that, without the minimum coverage provision, the Act's other reforms, such as the ban on denying coverage based on pre-existing conditions, would amplify existing incentives for individuals to "wait to purchase health insurance until they needed care," thereby further shifting costs onto

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[1] It also prevents insurers from rescinding coverage for any reason other than fraud or misrepresentation, or declining to renew coverage based on health status. *Id.* §§ 1001, 1201. And it prohibits caps on the amount of coverage available to a policyholder in a given year or over a lifetime. *Id.* §§ 1001, 10101(a).

[2] These provisions have been amended by the Health Care and Education Affordability Reconciliation Act of 2010, Pub. L. No. 111-152, § 1002, 124 Stat. 1029, 1032.

third parties. *Id.* §§ 1501(a)(2)(I), 10106(a). Congress concluded that the minimum coverage provision "is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." *Id.*

The CBO projects that the reforms in the Act will reduce the number of uninsured Americans by approximately 32 million by 2019. Letter from Douglas W. Elmendorf, Director, CBO, to the Hon. Nancy Pelosi, Speaker, U.S. House of Representatives 9 (Mar. 20, 2010) [hereinafter CBO Letter to Rep. Pelosi]. It further projects that the Act's combination of reforms, subsidies, and tax credits will reduce the average premium paid by individuals and families in the individual and small-group markets. *Id.* at 15; CBO, AN ANALYSIS OF HEALTH INSURANCE PREMIUMS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT 23-25 (Nov. 30, 2009). And the CBO estimates that the interrelated revenue and spending provisions in the Act – specifically taking into account revenue from the minimum coverage provision – will yield net savings to the federal government of more than $100 billion over the next decade. CBO Letter to Rep. Pelosi at 2.

PROCEDURAL HISTORY

Plaintiffs filed this suit on April 12, 2010. The complaint presents a facial challenge directed exclusively to the Act's minimum coverage provision, and seeks declaratory and injunctive relief holding unconstitutional the minimum coverage provision and striking down the ACA in its entirety on that basis.

STATEMENT OF QUESTIONS INVOLVED

1. Whether this Court has subject matter jurisdiction to determine the facial constitutionality of a statutory provision that does not go into effect until 2014.

2. Whether plaintiffs state a claim that Congress exceeded its constitutional authority in enacting a minimum coverage provision as part of its comprehensive health care reform legislation.

ARGUMENT

I. Standard of Review

Defendants move to dismiss this action for lack of subject matter jurisdiction under Rule 12(b)(1) of the Federal Rules of Civil Procedure. Plaintiffs bear the burden to "convince the court it has jurisdiction." *Gould Elecs., Inc. v. United States*, 220 F.3d 169, 178 (3d Cir. 2000). Where, as here, the defendant challenges jurisdiction on the face of the complaint, the complaint must plead sufficient facts to establish that jurisdiction exists. *See Common Cause v. Pennsylvania*, 558 F.3d 249, 257 (3d Cir. 2009). This Court must determine whether it has subject matter jurisdiction before addressing the merits of the complaint. *See Steel Co. v. Citizens for a Better Env't*, 523 U.S. 83, 94-95 (1998).

Defendants also move to dismiss this action under Federal Rule of Civil Procedure 12(b)(6) for failure to state a claim upon which relief can be granted. Under this rule, "the tenet that a court must accept as true all of the allegations contained in a complaint is inapplicable to legal conclusions. Threadbare recitals of the elements of a cause of action, supported by mere conclusory statements, do not suffice." *Ashcroft v. Iqbal*, 129 S. Ct. 1937, 1949 (2009); *see also Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007).

II. Plaintiffs' Claim Should Be Dismissed for Lack of Subject Matter Jurisdiction

In *DaimlerChrysler Corp. v. Cuno*, 547 U.S. 332 (2006), the Supreme Court reiterated that "[n]o principle is more fundamental to the judiciary's proper role in our system of government than the constitutional limitation of federal-court jurisdiction to actual cases or

controversies." *Id.* at 341 (internal quotation omitted). Plaintiffs' challenge to the minimum coverage provision does not present an actual case or controversy. First, because the provision has not caused plaintiffs any actual or imminent injury, they do not have standing to sue the federal government. Second, the Anti-Injunction Act independently bars plaintiffs' claim; resolution of that claim requires that a proper plaintiff follow the procedures set by law for a review of an allegedly invalid tax. Third, plaintiffs' challenge is unripe because it is entirely speculative whether the minimum coverage provision will ever injure plaintiffs' interests, and plaintiffs will suffer no hardship from deferring judicial resolution of their claims.

A. Plaintiffs Lack Standing Because They Have Alleged No Cognizable Injury That Is Fairly Traceable to the Minimum Coverage Provision

To have standing to challenge the Act's minimum health insurance coverage provision, plaintiffs must show that they have "suffered an injury in fact – an invasion of a legally protected interest which is (a) concrete and particularized, and (b) actual or imminent, not conjectural or hypothetical." *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992) (internal quotation omitted). In addition, plaintiffs must show "a causal connection between the injury and the conduct complained of," and that the injury is redressable by a favorable decision. *Id.* at 560-61.

Here, the "conduct complained of" is Congress's enactment of the minimum coverage provision. As plaintiffs point out, the provision includes an enforcement mechanism in the form of a penalty for failure to maintain a minimum level of health insurance coverage. Compl. ¶ 6. However, the prospect of this penalty cannot qualify as an imminent injury sufficient to confer standing on plaintiffs, for the simple reason that plaintiffs have not been assessed, and are not in imminent danger of incurring, any such penalty. Those who file tax returns for 2014 and later years must include the penalty on their tax returns for the year in question if they fail to maintain the required coverage for one or more months during the year. Pub. L. No. 11-148, §§ 1501,

10106. Thus, no one, including plaintiffs, could incur this penalty until the deadline for submission of 2014 taxes, at the earliest.[3] *See id.* Any claim of injury on that basis is therefore "'too remote temporally'" to support standing. *See Interfaith Cmty. Org. v. Honeywell Int'l, Inc.*, 399 F.3d 248, 255 (3d Cir. 2005) (quoting *McConnell v. FEC*, 540 U.S. 93, 226 (2003), which held a Senator lacked standing to challenge campaign ad regulations when his next campaign was five years in the future); *Whitmore v. Arkansas*, 495 U.S. 149, 155 (1990) (injury "must be concrete in both a qualitative and temporal sense"). Recognizing that the minimum coverage provision does not take effect until 2014, Compl. ¶ 20, plaintiffs implicitly acknowledge that the possibility of incurring a penalty at some point after that date cannot support a claim of imminent injury. Indeed, plaintiffs deny that they will ever incur this penalty, expressly asserting that they "will not voluntarily opt to . . . subject[] themselves to the otherwise unconstitutional Penalty." *Id.* ¶ 46.

Thus, rather than identifying the penalty – which is the only enforcement mechanism for the minimum coverage provision – as their injury, plaintiffs refer to an "immediate reduction of long-term purchasing power" due to the amount they predict they will have to spend on health insurance in 2014. *Id.* ¶ 31. Specifically, plaintiffs allege that they can neither "fully finance a new car prior to the effective date" of the provision, nor "afford a five (5) year financing deal for a new car" because, based on their estimate of their insurance costs beginning in January 1, 2014, their remaining disposable income as of that future date would be insufficient to cover the last fifteen months of car payments. *Id.* ¶¶ 44, 68. They further assert that they cannot spend their current disposable income as they wish because "they must now save those moneys in anticipation" of future health insurance costs. *Id.* ¶ 69. In other words, plaintiffs attempt to

[3] Only those who file tax returns for the year in question would be required to pay such a penalty.

avoid the conclusion that their claims are too speculative to support standing by alleging an injury that is at best indirect.

This roundabout reasoning does not demonstrate standing. For one thing, plaintiffs do not assert that their current lack of sufficient funds to buy a new car outright has anything to do with the minimum coverage provision. The point at which they claim to be unable to continue car payments is still some four years in the future. Moreover, even in regard to their asserted immediate need to save money, plaintiffs' calculations are based on their own speculative assumptions about what the future cost of minimum coverage might be. Plaintiffs' insurance expenses in 2014 may be lower than they predict – and may also be lower than their out-of-pocket health care expenses – for any number of reasons. For example, plaintiffs might obtain different employment that includes insurance as a benefit. Alternatively, due to unforeseen financial or medical circumstances, plaintiffs might qualify for Medicare or Medicaid.

Plaintiffs themselves assert that their current status as uninsured is entirely the result of an economic calculation regarding cost effectiveness. It necessarily follows that, if that calculation were to change at any time between now and 2014, their asserted injury would disappear.[4] Thus, if plaintiffs contract a serious illness or suffer an accidental injury requiring expensive medical treatments, they may willingly choose to purchase a policy as soon as the ACA's guaranteed issue provision goes into effect.[5] Similarly, upon reviewing the yet-to-be-created menu of insurance plans, plaintiffs may find one that they deem "cost effective" and

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[4] Plaintiffs do not object to health care or insurance on religious grounds. See Compl. ¶ 37. Rather, they assert that they discontinued their prior coverage based on an economic calculation after their insurance rates increased. Compl. ¶¶ 41-42.

[5] Indeed, by asserting that they cannot afford to make monthly payments on a new car if they buy health insurance in 2014, plaintiffs implicitly concede that, in the absence of insurance, they are financially unprepared to pay for any unexpected catastrophic health care needs that may arise.

accordingly choose to purchase it. At this point, four years before the minimum coverage goes into effect, plaintiffs' asserted injury is pure speculation. *See Shain v. Veneman*, 376 F.3d 815, 818 (8th Cir. 2004) ("[Plaintiffs] reason . . . a flood will certainly occur, albeit potentially many years from now. . . . [But] the plaintiffs must establish they will suffer the imminent injury. . . . [T]he possibility the flood will occur while they own or occupy the land becomes a matter of sheer speculation.").

Plaintiffs' asserted decision to save money and not to buy a new car cannot itself qualify as an imminent "injury" because, until plaintiffs actually purchase health insurance or incur a penalty for failing to do so, they cannot claim to have suffered a financial loss. *Cf. Miller v. Nissan Motor Acceptance Corp.*, 362 F.3d 209, 221-23 (3d Cir. 2004) (holding that the plaintiffs failed to allege a cognizable injury where they "never paid [an] early termination charge" and therefore "were not harmed by it," even if they had made the decision not to initiate early termination because of the lease provision that they sought to challenge). Indeed, the Supreme Court has recognized that a plaintiff's own description of his reasons for *not* acting is "uncorroborated oral evidence" that cannot support standing. *Blue Chip Stamps v. Manor Drug Stores*, 421 U.S. 723, 746 (1975) (individuals lacked standing to claim that a misleading stock prospectus caused them to decide not to purchase stock); *see also Sanner v. Bd. of Trade*, 62 F.3d 918, 924 (7th Cir. 1995) (individuals lacked standing to claim that a Board of Trade resolution causing depressed soybean prices caused them not to sell their soybeans). These cases recognize that plaintiffs cannot simply manufacture their own standing by claiming that the challenged action of a defendant caused them not to do something.

To the extent a plaintiff's decision not to do something constitutes an injury at all, it "stems not from the operation of [the challenged statute] but from [plaintiffs'] own . . . personal

choice." *See McConnell*, 540 U.S. at 228; *see also Utah Shared Access Alliance v. Carpenter*, 463 F.3d 1125, 1137-38 (10th Cir. 2006), *cert. denied*, 550 U.S. 904 (2007); *Nat'l Family Planning & Reprod. Health Ass'n v. Gonzales*, 468 F.3d 826, 831 (D.C. Cir. 2006). The minimum coverage provision does not require plaintiffs to take any action now. Thus, rather than satisfying standing, any decision that plaintiffs make to forego a purchase in the present in anticipation of future budgetary needs is not "fairly traceable" to the ACA. *Summers*, 129 S. Ct.. at 1149; *Sanner*, 62 F.3d at 924. As they are entitled to do, plaintiffs have decided to engage in future budgetary planning. But to hold that plaintiffs' independent calculations in the present could satisfy "causation" would gut the doctrine of standing, enabling all would-be plaintiffs to sue in order to challenge the most remote contingencies, on the ground that they have decided not to incur expenses in the present in anticipation of expenses they may later need to bear. The uncertainties, described above, of future health insurance costs, and of plaintiffs' future health care needs, remain, as does the fact that an inability to "afford coverage" in 2014, or a claim that purchasing insurance would cause financial hardship, could well qualify plaintiffs for one of the Act's exemptions. 26 U.S.C. § 5000A(e). In sum, plaintiffs satisfy neither the injury-in-fact nor the causation requirement under Article III, and the Court lacks jurisdiction over their claim.

B. Plaintiffs Cannot Evade the Procedures Prescribed by Law for an Individual to Contest a Liability under the Minimum Coverage Provision

Wholly apart from plaintiffs' failure to establish standing, this Court lacks jurisdiction for a second reason. Because, as noted above, the only statutory mechanism for enforcing the minimum coverage provision is the penalty that is assessed, beginning in 2014, on an individual's tax return, the relief that plaintiffs seek in this action necessarily would restrain the federal government from enforcing this penalty. *See* Compl. at 19-20 (seeking to enjoin the government from enforcing the minimum coverage provision). The Anti-Injunction Act

("AIA"), however, bars plaintiffs from seeking such relief. The AIA provides that, with exceptions inapplicable here, "no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court by any person, whether or not such person is the person against whom such tax was assessed." 26 U.S.C. § 7421(a). It does not matter that plaintiffs claim that they themselves will never incur this penalty because they plan to abide by the minimum coverage provision's requirement to maintain minimum health insurance coverage. The AIA "does not bar merely a taxpayer's attempt to enjoin the collection of his own taxes," but bars any suit seeking to enjoin the collection of taxes in general. *Alexander v. "Americans United," Inc.*, 416 U.S. 752, 760 (1974).

It also does not matter whether the payment sought to be enjoined is labeled as a "penalty" rather than a "tax." *Cf.* 26 U.S.C. § 5000A(b) (imposing a "penalty"). With exceptions immaterial here, that penalty is "assessed and collected in the same manner" as other penalties under the Internal Revenue Code, 26 U.S.C. § 5000A(g)(1), and, like these other penalties, falls within the bar of the AIA. 26 U.S.C. § 6671(a); *see Brounstein v. United States*, 979 F.2d 952, 954 & n.1 (3d Cir. 1992) (recognizing that those wishing to challenge an assessed penalty must first pay a portion of the penalty and then seek a refund); *Barr v. United States*, 736 F.2d 1134, 1135 (7th Cir. 1984) ("Section 6671 provides that the penalty at issue here is a tax for purposes of the Anti-Injunction Act."); *see also Mobile Republican Assembly v. United States*, 353 F.3d 1357, 1361-62 (11th Cir. 2003) (holding that penalties imposed on non-profit organizations for violation of the terms of their tax-exempt status "should be considered as part of the tax for purposes of analysis under the [AIA]" and that the AIA therefore barred plaintiffs from seeking injunctive relief).

Applying the AIA here serves its statutory purpose, to preserve the Government's ability

to collect such assessments expeditiously with "a minimum of preenforcement judicial interference and to require that the legal right to disputed sums be determined in a suit for refund." *Bob Jones Univ. v. Simon*, 416 U.S. 725, 736 (1974) (internal quotation omitted).[6] District courts accordingly lack jurisdiction to order the abatement of any liability for a tax or a penalty, apart from their power to consider validly-filed claims for refunds. *Iannelli v. Long*, 487 F.2d 317, 318 (3d Cir. 1973); *see also Bartley v. United States*, 123 F.3d 466, 467-68 (7th Cir. 1997). Plaintiffs have not identified any reason why they should be excused from the normal requirements of the AIA. Accordingly, the AIA bars their premature effort to enjoin enforcement of the minimum coverage provision.

C. Plaintiffs' Claim Is Not Ripe for Review

This Court lacks jurisdiction for a third reason: Plaintiffs' claim is not ripe for review. Ripeness "prevents courts from 'entangling themselves in abstract disagreements.'" *Surrick v. Killion*, 449 F.3d 520, 527 (3d Cir. 2006). Thus, in general, the availability of review depends on "(1) the fitness of the issues for judicial decision, and (2) the hardship of the parties of withholding court consideration." *Id.* (internal quotation omitted). Where, as here, a court is asked to issue a declaratory judgment based on its pre-enforcement review of a statute, "(1) the parties must have adverse legal interests; (2) the facts must be sufficiently concrete to allow for a conclusive legal judgment, and (3) the judgment must be useful to the parties." *Id.*

Here, the parties' interests do not qualify as "adverse" because plaintiffs do not face a "substantial threat of real harm." *See id.* Rather, plaintiffs' claim rests upon "contingent future

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[6] The Declaratory Judgment Act, 28 U.S.C. § 2201(a), similarly bars declaratory relief here, providing jurisdiction to the district courts to grant such relief "except with respect to Federal taxes." As the Supreme Court noted in *Bob Jones University*, 416 U.S. at 732 n.7, the tax exception to the Declaratory Judgment Act demonstrates the "congressional antipathy for premature interference with the assessment or collection of any federal tax."

events that may not occur as anticipated, or indeed may not occur at all." *See Thomas v. Union Carbide Agric. Prods. Co.*, 473 U.S. 568, 580-81 (1985) (internal quotation omitted). As explained above, changes in plaintiffs' health, employment, or financial situation between now and 2014 could lead them to acquire health insurance voluntarily or to qualify for an exception to the minimum coverage provision. Thus, the facts that will determine whether they might suffer a cognizable injury when the minimum coverage provision goes into effect in 2014 are unknown. This uncertainty renders the controversy unripe. *See Toilet Goods Ass'n v. Gardner*, 387 U.S. 158, 163-64 (1967).

Moreover, plaintiffs have failed to identify "an immediate harm with a 'direct effect on the[ir] day-to-day business.'" *Grand Lodge of Fraternal Order of Police v. Ashcroft*, 185 F. Supp. 2d 9, 17-18 (D.D.C. 2001) (quoting *Texas v. United States*, 523 U.S. 296, 301 (1998)). In *Abbott Laboratories v. Gardner*, 387 U.S. 136 (1967), the Supreme Court found such a "direct effect" because the regulated parties "risk[ed] serious criminal and civil penalties" if they failed to make immediate changes in their labeling and promotional activities. *Id.* at 152-53. Plaintiffs' assertion that they are now unable to buy a car because they anticipate needing a certain amount of money in the future to buy health insurance cannot establish a "direct effect" of the kind required. Rather, any changes they choose to make in their current budgetary allocations – which, as explained above, are not necessarily based on accurate assumptions about the future – are not compelled by any immediate requirement of the minimum coverage provision. *See, e.g.*, *Texas*, 523 U.S. at 301 (distinguishing *Abbott Labs*. from the case there under consideration, where the plaintiff "is not *required* to engage in, or to refrain from, any conduct" in order to avoid criminal sanction (emphasis added)); *A. O. Smith Corp. v. FTC*, 530 F.2d 515, 524 (3d Cir. 1976) (explaining that one "may not obtain pre-enforcement judicial

review of agency action if there is no immediate threat of sanctions for noncompliance, or if the potential sanction is de minimis"); *Bethlehem Steel Corp. v. EPA*, 536 F.2d 156, 163-64 (7th Cir. 1976) (asserted impacts on "long range capital planning" or anticipatory "allocation of funds" were insufficient to justify immediate judicial review).

In sum, withholding court consideration works no hardship on plaintiffs, since the law does not require them "to engage in, or to refrain from, any conduct" until it goes into effect. *Texas*, 523 U.S. at 301. As the Court has recognized repeatedly, "[d]etermination of the scope and constitutionality of legislation in advance of its immediate adverse effect in the context of a concrete case involves too remote and abstract an inquiry for the proper exercise of the judicial function." *Int'l Longshoremen's & Warehousemen's Union v. Boyd*, 347 U.S. 222, 224 (1954); *see also United States v. Raines*, 362 U.S. 17, 22 (1960) ("The delicate power of pronouncing an Act of Congress unconstitutional is not to be exercised with reference to hypothetical cases thus imagined."). Instead, the validity of the minimum coverage provision could be determined in the type of refund action the AIA seeks to preserve.

III. This Action Should Be Dismissed for Failure to State a Claim upon Which Relief May Be Granted

Even if this Court had subject matter jurisdiction, plaintiffs' constitutional challenge to the Act would fail. "Due respect for the decisions of a coordinate branch of Government demands that [this Court] invalidate a congressional enactment only upon a plain showing that Congress has exceeded its constitutional bounds." *United States v. Morrison*, 529 U.S. 598, 607 (2000). Moreover, in presenting a facial challenge to a federal statute, plaintiffs may prevail only "by 'establish[ing] that no set of circumstances exists under which the Act would be valid,' *i.e.*, that the law is unconstitutional in all of its applications." *Wash. State Grange v. Wash. State Republican Party*, 552 U.S. 442, 449 (2008) (quoting *United States v. Salerno,* 481 U.S. 739,

745 (1987)); *see also Nebraska v. EPA*, 331 F.3d 995, 998 (D.C. Cir. 2003) (rejecting facial Commerce Clause challenge to federal statute); *United States v. Sage*, 92 F.3d 101, 106 (2d Cir. 1996) (same). Plaintiffs cannot make this showing.

A. The Comprehensive Regulatory Measures of the ACA, Including the Minimum Coverage Provision, Are a Proper Exercise of Congress's Powers under the Commerce Clause and the Necessary and Proper Clause

Plaintiffs assert that the minimum coverage provision exceeds Congress's authority under the Commerce Clause. Their claim is mistaken, for two primary reasons. First, the provision regulates *economic* decisions regarding the way in which health care services are paid for – decisions that, in the aggregate, have a direct and substantial effect on interstate commerce. Second, Congress had far more than a rational basis to find the provision essential to the Act's larger (and unchallenged) regulatory effort to regulate the interstate business of insurance. The provision prohibits participants in the health care market from shifting the costs of their care to third parties, and also prevents individuals from relying on the Act's reforms (such as the ban on denying coverage to people with pre-existing conditions) to delay the purchase of health insurance until illness strikes. In short, on the basis of detailed Congressional findings, which were the product of extensive hearings and debate, the provision at issue directly addresses cost-shifting in those markets, quintessentially economic activity, and it is an essential element of a comprehensive, intricately interrelated regulatory scheme. Moreover, in focusing on services people almost certainly will receive, and regulating the economic decision whether to pay for health care in advance, through insurance, or to try to pay later, out of pocket, the provision – contrary to plaintiffs' claim – does not open the door to regulation of a full range of life choices. For these reasons, the provision falls well within the Constitution's broad grant of authority to Congress to regulate interstate commerce. And because the provision is reasonably adapted as a

means to accomplish the ends of the Act, it also falls well within Congressional authority under the Necessary and Proper Clause.

1. Congress's Authority to Regulate Interstate Commerce Is Broad

The Constitution grants Congress the power to "regulate Commerce . . . among the several States," U.S. CONST. art. I, § 8, cl. 3, and to "make all Laws which shall be necessary and proper" to the execution of that power, *id*. cl. 18. This grant of authority is broad. Congress may "regulate the channels of interstate commerce"; it may "regulate and protect the instrumentalities of interstate commerce, and persons or things in interstate commerce"; and it may "regulate activities that substantially affect interstate commerce." *Gonzales v. Raich*, 545 U.S. at 16-17; *Whited*, 311 F.3d at 265. In assessing whether an activity substantially affects interstate commerce, Congress may consider the aggregate effect of a particular form of conduct in deciding whether to exercise its Commerce Clause authority. The question is not whether any one person's conduct, considered in isolation, affects interstate commerce, but whether there is a rational basis for concluding that the *class of activities*, "taken in the aggregate" has some substantial effect on interstate commerce. *Raich*, 545 U.S. at 22; *Whited*, 311 F.3d at 265 (citing *Wickard v. Filburn*, 317 U.S. 111, 127-28 (1942)). In other words, "[w]here the class of activities is regulated and that class is within the reach of federal power, the courts have no power to excise, as trivial, individual instances of the class." *Raich*, 545 U.S. at 23 (internal quotation omitted); *United States v. Bishop*, 66 F.3d 569, 584 (3d Cir. 1995).

In exercising its Commerce Clause power, Congress may reach even wholly intrastate, non-commercial matters when it concludes that the failure to do so would undercut the operation of a larger program regulating interstate commerce. *Raich*, 545 U.S. at 18. When "a general regulatory statute bears a substantial relation to commerce, the *de minimis* character of

individual instances arising under that statute is of no consequence." *Id*. at 17 (internal quotation omitted); *see also id.* at 37 (Scalia, J., concurring in the judgment) (noting that Congress's authority to make its regulation of commerce effective is "distinct" from its authority to regulate matters that substantially affect interstate commerce).

In assessing these Congressional judgments regarding the impact on interstate commerce and the necessity of individual provisions to the overall scheme of reform, the task of the Court "is a modest one." *Raich*, 545 U.S. at 22. The Court need not itself measure the impact on interstate commerce of the activities Congress sought to regulate, nor need the Court calculate how integral a particular provision is to a larger regulatory program. The Court's task instead is to determine "whether a 'rational basis' exists" for Congress's conclusions, *id.* (quoting *United States v. Lopez*, 514 U.S. 549, 557 (1995)), giving "substantial deference" to Congress's determination that the activity being regulated is "sufficiently related to interstate commerce." *Whited*, 311 F.3d at 267; *accord Bishop*, 66 F.3d at 576. In other words, under rational basis review, this Court may not second-guess the factual record upon which Congress relied.[7]

The Supreme Court's decisions in *Raich* and in *Wickard* illustrate the breadth of the Commerce power and the deference accorded Congress's judgments. In *Raich*, the Court sustained Congress's authority to prohibit the possession of home-grown marijuana intended solely for personal use. It was sufficient that the Controlled Substances Act "regulates the production, distribution, and consumption of commodities for which there is an established, and lucrative, interstate market." *Raich*, 545 U.S. at 26. Likewise in *Wickard*, the Court upheld a penalty on wheat grown for home consumption despite the farmer's protests that he did not

[7] This Court accordingly may consider that record in its review of this motion to dismiss. *See Manor Care, Inc. v. Yaskin*, 950 F.2d 122, 128 (3d Cir. 1991) (recognizing that legislative history is properly considered when ruling on a motion to dismiss); *see also* FED. R. EVID. 201 advisory committee's note.

intend to put the commodity on the market. It was sufficient that the existence of homegrown wheat, in the aggregate, could "suppl[y] a need of the man who grew it which would otherwise be reflected by purchases in the open market," thus undermining the efficacy of the federal price stabilization scheme. *Wickard*, 317 U.S. at 128. Thus, in each case, the Court upheld obligations even on individuals who claimed not to participate in interstate commerce, because those obligations were components of broad schemes regulating interstate commerce.

Similarly, in *United States v. Kukafka*, 478 F.3d 531 (3d Cir. 2007), *cert. denied* 552 U.S. 866 (2007), the Third Circuit upheld the Deadbeat Parents Act because "although failure to pay child support might be a local activity, it is part of a national economic problem that substantially affects interstate commerce." *Id.* at 535. And in *Whited*, the Third Circuit recognized Congress' authority under the Commerce Clause to impose criminal penalties on local health care embezzlement where Congress could rationally conclude that "even seemingly minor local thefts or embezzlements in connection with health care" could, when taken in the aggregate, substantially affect interstate commerce, 311 F.3d at 270, and where the provision was "just one of a number of broad measures Congress enacted in its effort to combat waste, fraud, and abuse in health insurance and health care delivery." *Id.* at 268 (internal quotation omitted). The court recognized that, when viewed in the context of that larger "regulation of economic activity," the theft at issue was "fundamentally an economic endeavor." *Id.*

Both *Raich* and *Whited* came after the Court's decisions in *United States v. Lopez*, 514 U.S. 549 (1995), and *United States v. Morrison*, 529 U.S. 598 (2000), and thus highlight the central focus and limited scope of those decisions. Unlike *Raich* and *Whited*, and unlike this case, neither *Lopez* nor *Morrison* involved regulation of economic activity. And neither case addressed a measure that was integral to a comprehensive scheme to regulate activities in

interstate commerce. *Lopez* was a challenge to the Gun-Free School Zones Act of 1990, "a brief, single-subject statute making it a crime for an individual to possess a gun in a school zone." *Raich*, 545 U.S. at 23. Possessing a gun in a school zone is not an economic activity. Nor was the prohibition against possessing a gun "'an essential part of a larger regulation of economic activity, in which the regulatory scheme could be undercut unless the intrastate activity were regulated.'" *Id.* at 24 (quoting *Lopez*, 514 U.S. at 561). Indeed, the argument that the provision affected interstate commerce had to posit an extended chain reaction – guns near schools lead to violent crime; such violent crime imposes costs; and insurance spreads those costs. The Court found this reasoning too attenuated to sustain the gun law "'under [the Court's] cases upholding regulations of activities that arise out of or are connected with a commercial transaction, which viewed in the aggregate, substantially affects interstate commerce.'" *Id.* (quoting *Lopez*, 514 U.S. at 561). Likewise, the statute at issue in *Morrison* simply created a civil remedy for victims of gender-motivated violent crimes. *Id.* at 25. Gender-motivated violent crimes are not an economic activity either, and the statute at issue focused on violence against women, not on any broader regulation of economic activity.

2. The ACA, and the Minimum Coverage Provision, Regulate the Interstate Market in Health Insurance

Regulation of a vast interstate market that consumes more than 17.5% of the annual gross domestic product is well within the compass of congressional authority under the Commerce Clause. Pub. L. No. 111-148, §§ 1501(a)(2)(B), 10106(a). It has long been established that Congress has the power to regulate the interstate health insurance market. *See United States v. South-Eastern Underwriters Ass'n*, 322 U.S. 533, 553 (1944); *see also Whited*, 311 F.3d at 268 ("Given the complex state of modern health care delivery, it is difficult to envision any public or private health care plan or contract that does not affect commerce."). Congress has repeatedly

exercised its power over this field, both by providing directly for government-funded health insurance through the Medicare Act, and by adopting over a period of more than 35 years numerous statutes regulating the content of policies offered by private insurers.[8]

This long history of federal regulation of the health insurance market buttressed Congress's understanding that only it, and not the states, could act effectively to counter the national health care crisis. Because important components of health insurance regulation – for example, the Medicare program and the regulation of workplace-sponsored insurance through ERISA – are already provided by the federal government, "[e]xpecting states to address the many vexing health policy issues on their own is unrealistic, and constrains the number of states that can even make such an effort." *State Coverage Initiatives: Hearing Before the Subcomm.*

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[8] In 1974, Congress enacted the Employee Retirement and Income Security Act, Pub L. No. 93-406, 88 Stat. 829 ("ERISA"), which establishes federal requirements for health insurance plans offered by private employers. A decade later, Congress passed the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 82 ("COBRA"), which allows workers and their families who lose their health benefits under certain circumstances the right to continue receiving certain benefits from their group health plans for a time. In 1996, Congress enacted the Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, 110 Stat. 1936 ("HIPAA"), to improve access to health insurance by, among other things, generally prohibiting group plans from discriminating against individual participants and beneficiaries based on health status, requiring insurers to offer coverage to small businesses, and limiting the pre-existing condition exclusion period for group plans. 26 U.S.C. §§ 9801-03; 29 U.S.C. §§ 1181(a), 1182; 42 U.S.C. §§ 300gg, 300gg-1. HIPAA added similar requirements for individual insurance coverage to the Public Health Service Act. Pub. L. No. 104-191, § 111, 110 Stat. 1979. *See also* Mental Health Parity Act of 1996, Pub. L. No. 104-204, 110 Stat. 2944 (regulating annual or lifetime dollar limits on mental health benefits); Newborns' and Mothers' Health Protection Act of 1996, Pub. L. No. 104-204, 110 Stat. 2935 (requiring plans that offer maternity coverage to provide at least a 48-hour hospital stay following childbirth); Women's Health and Cancer Rights Act of 1998, Pub. L. No. 105-277, § 902, 112 Stat. 2681, 2681-436 (requiring certain plans to offer benefits related to mastectomies). More recently, Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, § 512, 122 Stat. 3765, 3881 ("MHPAEA"), requiring parity in financial requirements and treatment limitations for mental health benefits and medical and surgical benefits. MHPAEA §§ 701-02. The ACA builds on these laws regulating health insurance.

on Health of the H. Comm. on Ways and Means, 110th Cong. 7 (2008) (testimony of Alan R. Weil, Exec. Dir., National Academy of State Health Policy). Moreover, reform at the national level avoids the complexities, and thus the costs, that inevitably result from a reliance on a patchwork of state health insurance regulations. *Id.* at 28 (statement of Trish Riley, Director, Maine Governor's Office of Health Policy and Finance).

Congress accordingly undertook this comprehensive regulation of the interstate market in health insurance. The Act regulates health insurance provided through the workplace by adopting incentives for employers to offer or expand insurance coverage. The Act regulates health insurance provided through government programs by, among other things, expanding Medicaid. The Act regulates health insurance sold to individuals or in small group markets by establishing exchanges that enable individuals to pool their purchasing power and obtain affordable insurance. And the Act regulates the overall scope of health insurance coverage by affording subsidies and tax credits to the large majority of the uninsured; by ending industry practices that have made insurance unobtainable or unaffordable for many people; and, in Section 1501 of the Act, by requiring most Americans who can afford insurance to obtain a minimum level of coverage or to pay a penalty for the failure to do so.

Section 1501, like the Act as a whole, regulates decisions about how to pay for services in the health care market. These decisions are quintessentially economic, and are squarely within the traditional scope of Commerce Clause regulation. As Congress expressly recognized, "decisions about how and when health care is paid for, and when health insurance is purchased" are "economic and financial" and therefore "commercial and economic in nature." Pub. L. No. 111-148, §§ 1501(a)(2)(A), 10106(a).[9]

[9] Although Congress is not required to set forth particularized findings of an activity's effect on interstate commerce, when, as here, it does so, courts "will consider congressional

3. The Minimum Coverage Provision Regulates Conduct with Substantial Effects on Interstate Commerce

Congress needed no extended chain of inferences to determine that decisions about how to pay for health care, particularly decisions about whether to obtain health insurance or to attempt to pay for health care out of pocket, have in the aggregate a substantial effect on the interstate health care market. Individuals who forego health insurance coverage do not thereby forego health care. To the contrary, many of the uninsured will "receive treatments from traditional providers for which they either do not pay or pay very little, which is known as 'uncompensated care.'" CBO, KEY ISSUES, at 13; *see also* COUNCIL OF ECONOMIC ADVISERS ("CEA"), THE ECONOMIC CASE FOR HEALTH CARE REFORM 8 (June 2009) [hereinafter THE ECONOMIC CASE] (submitted into the record for *The Economic Case for Health Reform: Hearing Before the H. Comm. on the Budget*, 111th Cong. 5 (2009)). In this country, a minimum level of health care is guaranteed. Under the Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd, for example, hospitals that participate in Medicare and offer emergency services are required to stabilize any patient who arrives, regardless of whether he has insurance or otherwise can pay for that care. CBO, KEY ISSUES, at 13. In addition, most hospitals are nonprofit entities with "some obligation to provide care for free or for a minimal charge to members of their community who could not afford it otherwise." *Id*. For-profit hospitals "also provide such charity or reduced-price care." *Id*.

"Uncompensated care," of course, is not free of cost. In the aggregate, uncompensated care amounted to $43 billion dollars in 2008, or about 5 percent of overall hospital revenues. CBO, KEY ISSUES, at 114. These costs are subsidized by public funds. Through programs such as Disproportionate Share Hospital payments, the federal government paid for tens of billions of

findings in [their] analysis." *Raich*, 545 U.S. at 21; *accord Whited*, 311 F.3d at 269.

dollars in uncompensated care for the uninsured in 2008 alone. H.R. REP. NO. 111-443, pt. II, at 983 (2010); *see also* CEA, THE ECONOMIC CASE, at 8. The remaining costs are borne in the first instance by health care providers, which in turn "pass on the cost to private insurers, which pass on the cost to families." Pub. L. No. 111-148, § 1501(a)(2)(F), 10106(a). This cost-shifting effectively creates a "hidden tax" reflected in fees charged by health care providers and premiums charged by insurers. CEA, ECONOMIC REPORT OF THE PRESIDENT 187 (Feb. 2010); *see also* H.R. REP. NO. 111-443, pt. II, at 985 (2010); S. REP. NO. 111-89, at 2 (2009).

Furthermore, as premiums increase, more people who see themselves as healthy decide not to buy coverage. Plaintiffs expressly describe themselves in terms that place them within this category, explaining that when their premiums became more expensive, they decided "it was more cost effective . . . to pay medical bills as they come due." Compl. ¶¶ 41-42. This self-selection further narrows the risk pool and that, in turn, further increases the price of coverage for those who are insured. The result is a self-reinforcing "premium spiral." *Health Reform in the 21st Century: Insurance Market Reforms: Hearing Before the H. Comm. on Ways and Means*, 111th Cong. 118-19 (2009) (submission for the record of American Academy of Actuaries); *see also* H.R. REP. NO. 111-443, pt. II, at 985 (2010). Small employers particularly suffer from the effect of this premium spiral, due to their relative lack of bargaining power. *See* H.R. REP. NO. 111-443, pt. II, at 986-88 (2010); Statement of Raymond Arth, Nat'l Small Business Ass'n at 5 (June 10, 2008) (submitted into the record of *47 Million and Counting: Why the Health Care Market Is Broken: Hearing Before the S. Comm. on Finance*, 110th Cong. (2008)) (noting need for insurance reform and minimum coverage provision to limit growth of small business premiums).

Although many people have been unable to afford health insurance, the putative right to

make "fundamental economic choices" that plaintiffs seek to champion includes the decisions of some to engage in market timing. They will purchase insurance in later years, but choose in the short term to incur out-of-pocket costs with the safety net of the emergency room services that hospitals must provide whether or not the patient can pay. *See* CBO, KEY ISSUES at 12 (noting that the percentage of uninsured older adults in 2007 was roughly half the percentage of uninsured younger adults). By making the economic calculation to opt out of the health insurance pool during these years, these individuals skew premiums upward for the insured population. Yet, in later years when they need care, many of these uninsured will opt back into the health insurance system maintained in the interim by an insured population that has borne the costs of uncompensated care.

Thus, if the decision of some individuals not to obtain health insurance is rational, it is so because the health care system that was already in place before the ACA allowed such uninsured individuals to "free ride" – that is, to transfer many of their health care costs to commercial health care providers, insurers, and governments, who in turn must pass these costs on to the insured and to taxpayers. *See* CBO, KEY ISSUES, at 13-14; 155 Cong. Rec. H8002-8003 (July 10, 2009) (statement of Rep. Broun, citing cost-shifting by the uninsured); 155 Cong. Rec. H6608 (June 11, 2009) (statement of Rep. Murphy, same); 155 Cong. Rec. H4771 (Apr. 27, 2009) (statement of Rep. Fleming, same). *See also* CEA, THE ECONOMIC CASE, at 17 (explaining that "the uninsured obtain some free medical care through emergency rooms, free clinics, and hospitals, which reduces their incentives to obtain health insurance").

In the aggregate, these economic decisions regarding how to pay for health care services – including, in particular, decisions to forego coverage and to pay later or, if need be, to depend on free care – have a substantial effect on the interstate health care market. Congress may use its

Commerce Clause authority to regulate these direct and aggregate effects. *See Raich*, 545 U.S. at 16-17; *Wickard*, 317 U.S. at 127-28; *Whited*, 311 F.3d at 270.

Plaintiffs cannot brush aside these marketplace realities by characterizing the minimum coverage provision as compelling "affirmative private-sector economic conduct, as a condition of lawful residence within the United States," and claiming that it is therefore beyond the reach of the Commerce Clause. Nor are plaintiffs correct to assert that allowing regulation of such decisions removes all boundaries on the Commerce Clause. Compl. ¶¶ 24, 71. Those assertions misunderstand both the nature of the regulated activity and the scope of Congress's power. Congress found, and plaintiffs appear to concede, that the decision to try to pay for health care services without reliance on insurance is "economic and financial," Pub. L. No. 111-148, §§ 1501(a)(2)(A), 10106(a); *see also* Compl. ¶ 27 (describing decision to forego coverage as "economic"). But individuals who make that economic choice have not opted out of health care; they are not passive bystanders divorced from the health care market. They have chosen a method of payment for the services they will receive, no more "passive" than a decision to pay by credit card rather than by check. Indeed, plaintiffs themselves assert that they "have incurred and successfully satisfied payment of . . . medical expenses" since making the economic decision to forego insurance. Compl. ¶¶ 42-43. Congress specifically focused on those who have such an economic choice, exempting certain individuals who cannot purchase health insurance for religious reasons, as well as those who cannot afford insurance, or who would suffer hardship if required to purchase it. Pub. L. No. 111-148, §§ 1501(b), 10106(b) (as amended by Pub. L. No. 111-152, § 1002(b)) [hereinafter 26 U.S.C. § 5000A] (adding 26 U.S.C. § 5000A(d), (e)). And Congress found that this class of volitional economic decisions, taken in the aggregate, results each year in billions of dollars in uncompensated health care costs that are passed on to

governments and other third parties. *See, e.g.,* Pub. L. No. 111-148, §§ 1501(a)(2)(F), 10106(a). Plaintiffs attempt to cast the situation in diametrically opposite terms, suggesting that the minimum coverage provision is intended as a "pay-off to the healthcare insurance industry" and a subsidy for the "politically powerful, and aging 'baby-boomer' generation." Compl. ¶¶ 26-27. Their assertions miss the central point that the decisions of those who choose not to maintain insurance have a direct and substantial effect on the interstate health care market in which the uninsured participate. Those decisions thus are subject to federal regulation.

The ACA in fact regulates economic activity far more directly than provisions the Supreme Court has previously upheld. In *Wickard*, for example, the Court upheld a system of production quotas, despite the plaintiff farmer's claim that the statute effectively required him to purchase wheat on the open market rather than grow it himself. The Court reasoned that "[h]ome-grown wheat in this sense competes with wheat in commerce. The stimulation of commerce is a use of the regulatory function quite as definitely as prohibitions or restrictions thereon." 317 U.S. at 128; *see also id.* at 127 ("The effect of the statute before us is to restrict the amount which may be produced for market *and the extent as well to which one may forestall resort to the market* by producing to meet his own needs." (emphasis added)); *Heart of Atlanta Motel v. United States*, 379 U.S. 241, 258-59 (1964) (Commerce Clause reaches decisions *not to engage* in transactions with persons with whom plaintiff did not wish to deal); *Daniel v. Paul*, 395 U.S. 298 (1969) (same). And in *Raich*, the plaintiffs likewise claimed that their home-grown marijuana was "entirely separated from the market" and thus not subject to regulation under the Commerce Clause. The Court rejected their claim as well. 545 U.S. at 30. Here, the ACA regulates a class of individuals who almost certainly will participate in the health care market, who have decided to finance that participation in one particular way, and whose

decisions impose substantial costs on other participants in that market. Despite any claim by plaintiffs that they stand outside the market for health insurance, their economic decisions have a substantial effect on the larger market for health care services from which they do not stand apart. The Commerce Clause empowers Congress to regulate these economic decisions.

4. The Minimum Coverage Provision Is an Integral Part of the Larger Regulatory Scheme and Is Necessary and Proper to Congress's Regulation of Interstate Commerce

The minimum coverage provision is a valid exercise of Congress's powers for a second reason. The ACA's reforms of the interstate insurance market – particularly its requirement that insurers guarantee coverage for all individuals, even those individuals with pre-existing medical conditions – could not function effectively without the minimum coverage provision. The provision is an essential part of a larger regulation of interstate commerce, and thus, under *Raich,* is well within Congress's Commerce Clause authority. Analyzing the minimum coverage provision under the Necessary and Proper Clause leads to the same conclusion for fundamentally the same reason. The provision is a reasonable means to accomplish Congress's goal of ensuring access to affordable coverage for all Americans. It is therefore necessary and proper to the valid exercise of Congress's Commerce Clause power, and it stands on that basis as well.

a. The Minimum Coverage Provision Is Essential to the Comprehensive Regulation Congress Enacted

The minimum coverage provision is an essential part of the ACA's larger regulatory scheme for the interstate health care market. As explained above, the Act adopts a series of measures to increase the availability and affordability of health insurance, including measures to prohibit an array of insurance industry practices that have denied coverage or have increased premiums for those with the greatest health care needs. Beginning in 2014, the Act will bar insurers from refusing to cover individuals with pre-existing medical conditions, and from

setting eligibility rules based on health status, medical condition, claims experience, or medical history. Pub. L. No. 111-148, § 1201. Plaintiffs do not and cannot contend that these provisions, which directly regulate the content of insurance policies sold nationwide, are outside the scope of the Commerce Clause power. *See, e.g.*, *South-Eastern Underwriters Ass'n*, 322 U.S. at 553.

Congress found that, absent the minimum coverage provision, these new regulations would encourage more individuals to forego insurance, thereby aggravating current problems with cost-shifting and increasing insurance prices. The new insurance regulations would allow individuals to "wait to purchase health insurance until they needed care" – at which point the ACA would obligate insurers to provide those individuals with health insurance, subject to no coverage limits and despite the pre-existing conditions they may have at that time. Pub. L. No. 111-148, §§ 1501(a)(2)(I), 10106(a). These regulations thus increase the incentives for individuals to "make an economic and financial decision to forego health insurance coverage" until their health care needs become substantial, *id.* §§ 1501(a)(2)(A), 10106(a), taking advantage of the ACA's reforms to join a coverage pool that has been maintained in the interim by the premiums paid by other market participants. Without a minimum coverage provision, this market timing would increase the costs of uncompensated care and the premiums for the insured, creating pressures that would "inexorably drive [the health insurance] market into extinction." *Health Reform in the 21st Century*, at 13 (written statement of Uwe Reinhardt, Ph.D., Professor of Political Economy, Economics, and Public Affairs, Princeton University).[10] Accordingly, Congress found that the minimum coverage provision is "essential" to its broader effort to

[10] *See also id.* at 101-02 (testimony of Dr. Reinhardt); *id.* at 123-24 (submission for the record of National Association of Health Underwriters) (observing, based on the experience of "states that already require guaranteed issue of individual policies, but do not require universal coverage," that "[w]ithout near universal participation, a guaranteed-issue requirement . . . would have the perverse effect of encouraging individuals to forego buying coverage until they are sick or require sudden and significant medical care").

regulate health insurance industry underwriting practices that have prevented many from obtaining health insurance, Pub. L. No. 111-148, §§ 1501(a)(2)(I), (J), 10106(a).

In other respects as well, the minimum coverage provision is essential to the Act's comprehensive scheme to ensure that health insurance is available and affordable. In addition to regulating industry underwriting practices, the Act promotes availability and affordability through (a) "health benefit exchanges" that enable individuals and small businesses to obtain competitive prices for health insurance, (b) incentives for employers to offer expanded insurance coverage, (c) tax credits to certain low-income and middle-income individuals and families, and (d) the extension of Medicaid to individuals with lower incomes. The minimum coverage provision works in tandem with these and other reforms, to reduce the upward pressure on premiums caused by medical underwriting. The latter practice, involving individualized review of an applicant's health status, is costly, resulting in administrative fees that are responsible for 26 to 30 percent of the cost of premiums in the individual and small group markets. Pub. L. No. 111-148, §§ 1501(a)(2)(J), 10106(a). And medical underwriting yields substantially higher risk-adjusted premiums or outright denial of insurance coverage for an estimated one-fifth of applicants. CBO, KEY ISSUES, at 81. "By significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the [minimum coverage] requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums," and is therefore "essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs." Pub. L. No. 111-148, §§ 1501(a)(2)(J), 10106(a).

Congress thus rationally found that a failure to regulate the decision to forego insurance – *i.e.,* the decision to shift one's costs on to the larger health care system – would undermine the

"comprehensive regulatory regime," *Raich,* 545 U.S. at 27, framed in the Act. Specifically, Congress had ample basis to conclude that a failure to regulate this "class of activity" would "undercut the regulation of the interstate market" in health insurance. *Raich*, 545 U.S. at 18; *see id.* at 37 (Scalia, J., concurring in the judgment) ("Congress may regulate even noneconomic local activity if that regulation is a necessary part of a more general regulation of interstate commerce."). Without the minimum coverage provision, insurance risks would be spread across a smaller and less healthy pool of insureds, driving up costs and thereby undermining Congress's efforts, through health benefit exchanges, employer incentives and tax credits, to ensure the availability of affordable health insurance. The minimum coverage provision is thus an integral part of the ACA's "comprehensive framework for regulating" healthcare, *Raich,* 545 U.S. at 24, and that broad regulation of the interstate health care market is plainly within Congress's Article I authority. The Commerce Clause requires nothing more. *See Hodel v. Indiana*, 452 U.S. 314, 329 n.17 (1981).

b. The Minimum Coverage Provision Is a Valid Exercise of Congress's Power under the Necessary and Proper Clause

Because the minimum coverage provision is essential to Congress's overall regulatory reform of the interstate health care and health insurance markets, it is also a valid exercise of Congress's authority under the Necessary and Proper Clause, U.S. CONST., art. I, § 8, cl. 18, to accomplish that goal. "[T]he Necessary and Proper Clause grants Congress broad authority to enact federal legislation." *United States v. Comstock*, No. 08-1224, 2010 WL 1946729, at *5 (U.S. May 17, 2010). It has been settled since *M'Culloch v. Maryland*, 17 U.S. (4 Wheat.) 316 (1819), that this clause affords Congress the power to employ any means "reasonably adapted to the end permitted by the Constitution." *Hodel v. Va. Surface Mining & Reclamation Ass'n*, 452 U.S. 264, 276 (1981) (internal quotation omitted). And when Congress legislates in furtherance

of a legitimate end, its choice of means is accorded broad deference. *See Sabri v. United States,* 541 U.S. 600, 605 (2004) (explaining that *M'Culloch* established "review for means-ends rationality under the Necessary and Proper Clause"); *see also Comstock*, 2010 WL 1946729, at *6; *United States v. Shenandoah*, 572 F. Supp. 2d 566, 577 & n.7 (M.D. Pa. 2008) (recognizing validity of sex offender registration law under both Commerce Clause and Necessary and Proper Clause), *aff'd by* 595 F.3d 151 (3d Cir. 2010) (upholding Commerce Clause analysis without reaching Necessary and Proper Clause). "[W]here Congress has the authority to enact a regulation of interstate commerce, 'it possesses every power needed to make that regulation effective.'" *Raich*, 545 U.S. at 36 (Scalia, J., concurring in the judgment) (quoting *United States v. Wrightwood Dairy Co.*, 315 U.S. 110, 118-19 (1942)).

As Congress found, the minimum coverage provision not only is adapted to, but indeed is "essential" to achieving key reforms of the interstate health insurance market. As noted, the Act imposes requirements on insurers, which bar them from denying coverage or charging higher rates based on medical conditions, including pre-existing conditions. There can be no reasonable dispute that Congress has the power under the Commerce Clause to impose these requirements, and indeed they are consistent with decades of Congressional regulation of the offerings of private insurers. *See supra* note 8. Without the minimum coverage provision, healthy individuals would have overwhelmingly strong incentives to forego insurance coverage, knowing that they could obtain coverage later if and when they became ill. As a result, the cost of insurance would skyrocket, and the larger system of reforms would fail. *See, e.g.*, *Health Reform in the 21st Century*, at 13 (written statement of Dr. Reinhardt). Congress thus rationally concluded – indeed, the logic is compelling – that the minimum coverage provision is necessary to make the other regulations in the Act effective, and the provision is easily justified under the

Necessary and Proper Clause. *See Comstock*, 2010 WL 1946729, at *7 ("'If it can be seen that the means adopted are really calculated to attain the end, the degree of their necessity, the extent to which they conduct to the end, the closeness of the relationship between the means adopted and the end to be attained, are matters for congressional determination alone.'") (quoting *Burroughs v. United States*, 290 U.S. 534, 547-48 (1934)).

B. The Minimum Coverage Provision Is a Valid Exercise of Congress's Independent Power Under the General Welfare Clause

Plaintiffs' challenge here fails on the merits for an additional reason. Independent of its Commerce Clause authority, Congress is vested with the "Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States[.]" U.S. CONST. art. I, § 8, cl. 1. Subject to nominal constraints concerning the allocation of particular types of taxes, the power of Congress to use its taxing and spending power under the General Welfare Clause has long been recognized as "extensive." *License Tax Cases*, 72 U.S. at 471; *see also McCray v. United States*, 195 U.S. 27, 56-59 (1904); *United States v. Doremus*, 249 U.S. 86, 93 (1919); *Charles C. Steward Mach. Co. v. Davis*, 301 U.S. 548, 581 (1937). Congress may use its power under this Clause even for purposes that would exceed its powers under the other provisions of Article I. *See United States v. Sanchez*, 340 U.S. 42, 44 (1950) ("Nor does a tax statute necessarily fall because it touches on activities which Congress might not otherwise regulate."); *see also United States v. Butler*, 297 U.S. 1, 66 (1936); *Knowlton v. Moore*, 178 U.S. 41, 59-60 (1900) (Congress could tax inheritances, even if it could not regulate inheritances under the Commerce Clause).

Although "the constitutional restraints on taxing are few," *United States v. Kahriger*, 345 U.S. 22, 28 (1953), *overruled in part on other grounds by Marchetti v. United States*, 390 U.S. 39 (1968), one such limitation is that this power must be used to "provide for the . . . general

Welfare." U.S. CONST., art. I, § 8, cl. 1. As the Supreme Court held seventy-five years ago with regard to the Social Security Act, such decisions of how best to provide for the general welfare are for the representative branches, not for the courts. *Helvering v. Davis*, 301 U.S. 619, 640 (1937); *id.* at 645 & n.10; *see also South Dakota v. Dole*, 483 U.S. 203, 207 (1987).

The minimum coverage provision falls within Congress's "extensive" General Welfare authority. *License Tax Cases*, 72 U.S. at 471. The Act requires individuals not otherwise exempt to obtain "minimum essential coverage" or pay a penalty. 26 U.S.C. § 5000A(a), (b)(1). The provision is part of the Internal Revenue Code and does not apply to individuals who are not required to file income tax returns for a given year. *Id.* § 5000A(e)(2). In general, the penalty is calculated as the greater of a fixed amount or a percentage of the individual's household income, but cannot exceed the national average premium for the lowest-tier plans offered through health insurance exchanges for the taxpayer's family size. *Id.* § 5000A(c)(1), (2). If the penalty applies, it must be reported on a taxpayer's return for the taxable year, as an addition to the total income tax liability. *Id.* § 5000A(b)(2). The penalty is assessed and collected in the same manner as other penalties imposed under the Internal Revenue Code.[11]

That the provision has a regulatory purpose does not place it beyond Congress's taxing power.[12] *Sanchez*, 340 U.S. at 44 ("It is beyond serious question that a tax does not cease to be

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[11] The Secretary of the Treasury may not collect the penalty by means of liens or levies, and may not bring a criminal prosecution for a failure to pay the penalty. 26 U.S.C. § 5000A(g)(2). The revenues derived from the minimum coverage penalty are paid into general revenues.

[12] Congress has long used the taxing power as a regulatory tool, and in particular as a tool to regulate how health care is paid for in the national market. HIPAA, for example, limits the ability of group health plans to exclude or terminate applicants with pre-existing conditions, and imposes a tax on any such plan that fails to comply with these requirements. 26 U.S.C. §§ 4980D, 9801-03. In addition, the Internal Revenue Code requires group health plans to offer COBRA continuing coverage to terminated employees, and similarly imposes a tax on any plan that fails to comply with this mandate. 26 U.S.C. § 4980B.

valid merely because it regulates, discourages, or even definitely deters the activities taxed."); *see also Kahriger*, 345 U.S. at 27-28; *cf. Bob Jones Univ.*, 416 U.S. at 741 n.12 (noting that the Court has "abandoned" older "distinctions between regulatory and revenue-raising taxes").[13] So long as a statute is "productive of some revenue," the courts will not second-guess Congress's exercise of its General Welfare Clause powers and "will not undertake, by collateral inquiry as to the measure of the regulatory effect of a tax, to ascribe to Congress an attempt, under the guise of taxation, to exercise another power denied by the Federal Constitution." *Sonzinsky v. United States*, 300 U.S. 506, 514 (1937); *see United States v. Grier*, 354 F.3d 210, 215 (3d Cir. 2003).

The minimum coverage provision easily meets this standard. The Joint Committee on Taxation specifically included the provision in its review of the "Revenue Provisions" of the Act and the Reconciliation Act, analyzing the provision as a "tax," an "excise tax," and a "penalty." *See* Joint Comm. on Taxation, 111th Cong., *Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010," as amended, in Combination with the "Patient Protection and Affordable Care Act"* 31 (Mar. 21, 2010).[14] Moreover, the Joint Committee, along with the CBO, on multiple occasions predicted how much revenue this provision would raise and considered that amount in determining the impact of the bill on the deficit. In assessing the final

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[13] Nor does the statutory label of the minimum coverage provision as a "penalty" matter. "In passing on the constitutionality of a tax law [the Court is] concerned only with its practical operation, not its definition or the precise form of descriptive words which may be applied to it." *Nelson v. Sears, Roebuck & Co.*, 312 U.S. 359, 363 (1941) (internal quotation omitted); *see also Penn Mut. Indem. Co. v. C.I.R.*, 277 F.2d 16, 20 (3d Cir. 1960) ("Congress has the power to impose taxes generally, and if the particular imposition does not run afoul of any constitutional restrictions then the tax is lawful, call it what you will." (footnote omitted)).

[14] The Joint Committee on Taxation is "a nonpartisan committee of the United States Congress, originally established under the Revenue Act of 1926" that "is closely involved with every aspect of the tax legislative process." *See* Joint Committee on Taxation, Overview, http://www.jct.gov/about-us/overview.html; *see also* 26 U.S.C. §§ 8001-23.

version of the bill, the CBO estimated that the minimum coverage provision would produce about $4 billion in annual revenue once it is fully in effect. CBO Letter to Rep. Pelosi at tbl. 4 at 2. Thus, as Congress recognized, the minimum coverage provision produces revenue alongside its regulatory purpose, which is all that Article I, Section 8, Clause 1 requires.

In any event, just as a court should interpret the "words of a statute . . . in their context and with a view to their place in the overall statutory scheme," *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 133 (2000) (internal quotation omitted), so, too, the Court should analyze the purpose and function of the minimum coverage provision in context, as an integral part of the overall statutory scheme it advances. Here, in order to expand insurance coverage, Congress, among other things, enacted tax credits for individuals and employers as well as tax penalties for certain employers that do not offer insurance, offered subsidies to low income households to purchase insurance from the health benefit exchanges, broadened eligibility for Medicaid and authorized significant federal expenditures to cover the increased costs of that expansion, and made additional tax assessments on pharmaceutical and medical device manufacturers, as well as insurance companies, to help finance the additional coverage. In determining the budgetary impact of the legislation, the CBO examined the combined, interconnected effect of all these provisions. *See* CBO Letter to Rep. Pelosi at 2-6 & tbl.1, tbl.2.

Congress reasonably concluded that the minimum coverage provision would increase the number of persons with insurance, permit the restrictions imposed on insurers to function efficiently, and lower insurance premiums. Pub. L. No. 111-148, §§ 1501(a), 10106(a). And Congress determined, also with substantial reason, that this provision was essential to the success of its comprehensive scheme of reform. Congress acted well within its prerogatives under the General Welfare Clause to include the minimum coverage provision as an integrated

component of the interrelated revenue and spending provisions in the Act, and as a measure necessary and proper to the overall goal of advancing the general welfare. *See, e.g.*, *Buckley v. Valeo*, 424 U.S. 1, 90 (1976) (grant of power under the General Welfare Clause "is quite expansive, particularly in view of the enlargement of power by the Necessary and Proper Clause").

CONCLUSION

For the foregoing reasons, this case should be dismissed pursuant to Fed. R. Civ. P. 12(b)(1) for lack of subject-matter jurisdiction, or, in the alternative, pursuant to Fed. R. Civ. P. 12(b)(6) of those Rules for failure to state a claim upon which relief may be granted.

DATED this 14th day of June, 2010.

Respectfully submitted,

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CERTIFICATE OF SERVICE

Pursuant to Local Rule 4.1, I hereby certify that the foregoing Memorandum was served via ECF on counsel of record for plaintiffs in the above-captioned case.

Dated: June 14, 2010

/s/ Kathryn L. Wyer
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